DOCUMENT RESUME

ED 163 685 EC 112 555

AUTHOR	Gillespie, Patricia H., Ed.; Middleton, Thomas O., Ed.
TITLE	Conference on Learning Disabilities: A Review of Indiana's Rule S-1. LD Series #5.
INSTITUTION	Indiana Univ., Bloomington. Center for Innovation in Teaching the Handicapped.
PUB DATE	76
NOTE	81p.; Best copy available
AVAILABLE FROM	Indiana University, Center for Innovation in Teaching the Handicapped, School of Education, Bloomington, Indiana 47401
EDRS PRICE	MF-$0.83 HC-$4.67 Plus Postage.
DESCRIPTORS	Auditory Perception; Conference Reports; Counselors; Due Process; *Exceptional Child Services; *Learning Disabilities; Neurology; Ophthalmology; Parents; Speech; *State Legislation; Student Evaluation; Student Placement
IDENTIFIERS	Indiana; *Rule S1

ABSTRACT

The document is a collection of papers presented at a conference on the delivery of services to learning disabled children in Indiana that focused on Indiana's Rule S-1, which implements the mandatory special education act through multidisciplinary identification, assessment, and placement of handicapped children. Titles and authors include "The Case Conference Committee and the Neurologically Impaired/Learning Disabled" (F. Kladder), "Historical and Future Trends in Learning Disabilities" (G. Gregersen), "Let's Get Some Questions Answered" (J. Poteet), "Comments on Rule S-1 As Applied to Learning Disabilities" (S. Schnitzer), "A Parent's Position Paper on Rule S-1" (R. Reed), "S-1 Regulations and the Pediatric Neurologist" (A. Drew), "Pediatricians Role in Implementing S-1" (L. Wojcik), "Learning Disabilities" (J. Fadely, G. DeBrota), "Rule S-1 and the Learning Disabilities Teacher" (B. Kichler), "Indiana State Teachers Association" (Rule S-1 Task Force), "The Role of Vision in Learning Disorders" (M. Allen), "The Ophthalmologist's Role in the Diagnosis and Treatment of Learning Disabilities" (E. Helveston, F. Ellis), "Considerations for Implementation of Rule S-1" (D. Miller), "The Role of the School Counselor in Relation to Learning Disabilities and Rule S-1" (S. Crowe), "The Role of the Pupil Personnel Team in Relation to Learning Disabilities and Rule S-1" (S. Crowe), and "American Speech and Hearing Association's Position on Learning Disabilities". Also provided are group synopses on definition, eligibility, data gathering, placement and due process, programing, and evaluation. (DLS)

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Conference on Learning Disabilities: A Review of Indiana's Rule S-1

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FORWARD

The Child Service Demonstration Center (CSDC) for children with learning disabilities at the Center for Innovation in Teaching the Handicapped (CITH), Indiana University and the Indiana Chapter of the American Academy of Pediatricians sponsored a conference regarding the delivery of services to learning disabled children in Indiana. Implementing the Mandatory Special Education Law of 1969, Chapter 396 Act of 1969, Rule S-1 has met with confusion. The lack of clear definitions readily understood and accepted by physicians, educators, psychologists, and social workers seems to be a major cause of the confusion, but the inability of these groups to communicate with one another is also a major factor. The conference was an attempt to establish lines of communication among these groups so that acceptable definitions and guidelines could be developed in order to enhance implementation of Rule S-1. It is hoped that this conference and its proceedings will stimulate interdisciplinary communication and consequently enable children with learning disabilities to benefit fully from the resources which the state can offer.

Melvyn I. Semmel
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PROLOGUE

In a brief and conclusive manner, the 1969 session of the Indiana State Legislation, amended the education act to include ALL children in the category of those for whom public education was mandated. Thereby, they set the stage for a massive change in our approach to educate children who are physically and emotionally handicapped, mentally retarded, and/or learning disabled.

The Department of Public Instruction was charged with the implementation of this amended act. It has been slow and deliberate in promulgation of the rules to enforce this public law. They have made a laudable effort to secure equal educational opportunities for ALL children. However, the atmosphere of this process has been charged with emotion. Then too, the pecuniary responsibilities of the state were given considerable weight in the development of the rule. The Department of Public Instruction, in interpreting the act, has extended its responsibility from the traditional years to encompass the period ranging from early infancy into adulthood. The rule has been based on theoretical and untried models, primarily because there was no significant agreement on many aspects of this broad subject. Consequently, the rule uses words without meaning, words with double meanings, and definitions not only unclear to those who wrote them, but equally confusing to those trying to interpret them. As a result, parents, teachers, and administrative personnel throughout the whole heirarchy of education are confused. Many of them lack understanding of the methods by which a child is placed in the program, and of the correct procedure to follow once the child has been so placed. Nor, has the financial impact upon the individual school system and upon the state

yet been fully appreciated.

Persons of goodwill and understanding readily appreciate the goals of this effort to provide education for ALL children and applaud them. However, the implementation to reach goals has been confusing and has created bitter feelings, from which the whole program has suffered.

This confusion became particularly poignant to Dr. Pat Gillespie, an educator, and to Dr. Thomas Middleton, a pediatrician. Dr. Gillespie became involved in the implementation of Rule S-1 as Director of Learning Disability Resource Center at Indiana University. Dr. Middleton's involvement was resultant of his being Director of School Health for the Monroe County Community School Corporation. It quickly became apparent to us that if we, who supposedly understood education and the processes of Rule S-1, could not agree among ourselves on definition and procedure, then the confusion throughout the state must be monumental. This view was reinforced by conversations with the Department of Public Instruction and individuals involved with special education efforts, and by the findings of conferences held throughout the state by the Division of Special Education of the DPI.

A plan was developed to bring together those individuals in the state who were involved in the various disciplines required to adequately implement Rule S-1. It was our goal to get them to come to some agreement, to understand one another, and to provide a rational and readily understood approach to meet the goals of the legislators as well as of the rule itself.

To this end, a conference was held May 1975 at the Nashville Ramada Inn. This conference was initially supported by the Indiana Chapter of the American Academy of Pediatrics and the Center for Innovation in

Teaching the Handicapped. The bulk of support came from parents and professional organizations within the state who sent representatives to attend the conference. The scope of representation included parents, physicians from various specialities, social workers, psychologists, and educators. The DPI lent great moral and technical support and participated wholeheartedly in the conference. With few exceptions, every statewide organization invited to send representatives did so.

The format of the conference was to present a series of position papers from each of these disciplines, to discuss these papers, and to reach specific recommendations for the group to consider. These positions were presented in the morning session with time allotted for participants to question each of the speakers. In the afternoon session, six groups, each composed of a variety of disciplines, were given topics related to aspects of evaluation and placement of learning disabled children. These groups generated recommendations for implementation of the rules and regulations.

We invite you now to consider the position papers and the conclusions reached in each of the workshops. Each of you can reach your own conclusions and we sincerely urge you to do so. Our conclusions and recommendations from this conference are included in the summary of this pamphlet.

We implore each of you to seriously consider the importance of this approach to meet the educational needs of that group of individuals who have been denied the opportunity to develop to their fullest their potentials. We cannot over-emphasize the importance of your support and understanding of this process, to make it acceptable to all facets of our community, and to truly meet the needs of those to whom the rule applies.

P.H.G.

T.O.M.

THE CASE CONFERENCE COMMITTEE AND THE NEUROLOGICALLY IMPAIRED/LEARNING DISABLED

Fred Kladder

The passage of Rule S-1, implementing the mandatory special education act, has established a multidisciplinary group approach to the identification, assessment, programming, placement, and monitoring of children into, through, and out of Special Education. More specifically, Rule S-1 states:

> The superintendent or his designee of the school attended by the child shall convoke a case conference committee to consider the appropriate educational placement for that child. The case conference committee shall be composed of appropriate school administrators, specialists, special education teachers, and/or regular education teachers who may have knowledge of the child and the parents of the child being considered for special education programs unless the parents choose not to participate.

The context in which the case conference committee operates is also clearly established in Rule S-1:

> To be fully effective, educational programming for students who may benefit from special education placement requires a team effort involving parents, teachers, school administrators, and specialists. Teamwork of this kind rests upon mutual trust and frequent communication...

The case conference committee provides a forum for this communication and mutual trust between the various partners involved in the education process for handicapped persons. Besides providing for parental involvement and legal safeguards in programming and placement, the case conference committee establishes a group recommendation-making model whereby no one member of the committee can unilaterally determine a child's program.

The major functions of a case conference committee include: determination of eligibility for special education programs, determination of appropriate special education placement, individual educational planning, and at least an annual review of the adequacy of the child's special education program (placement plus individual educational plan). While the parents and local

superintendent have the actual responsibility and decision making power, the case conference committee plays the critical role of assisting and advising in this process.

Rule S-1 specifically establishes the major functions of the case conference committee in relation to neurologically impaired/learning disabled (NI/LD) programs:

> Determination of appropriate placement in a special education program for students with a neurological impairment/learning disability shall be made by a case conference committee which will consider the results of a psychological evaluation as well as other school and health information. A written report shall be made by this committee which includes recommendations regarding eligibility of the pupil for a special education program and admission of the pupil to the most appropriate program. (emphasis added)

For most handicapping categories, individual members of the case conference committee are not specified. This leaves the exact composition of the committee up to local practices and policy. In most instances the number and type of specialists on a committee are determined by the concerns and questions which need to be answered about a given child. However, Rule S-1 does identify a critical specialist to be involved in determining a given child's eligibility for an NI/LD program:

> Establishment of pupil eligibility for services in a special education program for students with neurological impairments/ learning disabilities shall be made upon the basis of a written report of an individual evaluation which shall be performed by a physician with an unlimited license to practice medicine and who is trained in the speciality of neurology, pediatrics, internal medicine or psychiatry. (emphasis added)

While the above statement does not specify what this report should say, the implicit assumption seems to be that the physician's report should be supportive of an NI/LD placement. The decision of whether or not the physician's report is supportive or whether additional information of a psycho-neurological

nature is needed rests with the case conference committee. Since in many cases the demands for the medical specialist's time and services are great, he may not be able to attend the case conference committee's meeting. Consequently, it is imperative for his report to clearly communicate his recommendations regarding eligibility. This communication could be facilitated by the school's providing a form to the physician which would include such statements as: "Based on my evaluation of this child I would/would not be supportive of an NI/LD placement." Perhaps statements such as the above would help avoid situations wherein members of the committee are left to decipher the results of various neurological tests with which they may or may not be familiar.

Although the involvement of the physician in the evaluation of a potential NI/LD child is clearly specified by S-1, it would be unfair to place the sole responsibility on his/her shoulders or to consider his input apart from the case conference committee. In an area such as NI/LD where definitions and assessment procedures are complex and varied, the multidisciplinary group approach of the case conference committee is critical to insure appropriate and quality programs while safeguarding the legal and human rights of the individual.

HISTORICAL AND FUTURE TRENDS IN LEARNING DISABILITIES

Gerald Gregersen

Learning disabilities can be traced back at least 3000 years to the ancient Egyptians (Coleman, 1972). At that time, persons with severe head injuries were often observed to manifest impairments in speech or memory without other concomitant deficits. While some awareness of brain injury and its effects on language and cognition has existed for several thousand years, the concept of "learning disabilities" dates only to the 1860's and 1870's. Further, it has only been within the past twenty years that concerted efforts have been made to identify and serve the educational needs of children defined as learning disabled. Even with this surging interest in learning disabilities, fewer than one-half the school districts in the United States have clearly established programs for LD children.

One reason for the void in services has been the absence of a universally accepted definition as well as insufficient funds, trained teachers and physical facilities. Definitions do exist, but general consensus as to who is learning disabled and should receive service has not been clearly established. Identification of exceptional children who are deaf, blind, severely retarded or physically handicapped involves relatively minor controversy. Identification of the mildly retarded, socially maladjusted, emotionally disturbed and learning disabled children is more difficult. Difficulties with definition, imprecise diagnostic and measurement tools, as well as social and economic realities

all tend to further cloud the issue of educational service to children in need.

Two further issues should be examined. First, the American society has not demonstrated a commitment to providing optimum educational services to all persons. This is evident by the low levels of state aid to education across the country. Furthermore, a tremendous disparity in funding speical education programs exists in different states with LD often neglected.

Second, professional jealousies have inhibited the development and implementation of services. Physicians, psychologists, educators, and optometrists have all staked claims in the field of learning disabilities. While all these disciplines have valuable information to offer, internal squabbles continued to plague the delivery of services. One example is the state requirement that the physician serve as the gatekeeper for entry in educational learning disability programs. Several questions come to mind. Are all learning disabilities neurologically based? If so, at what point is the line drawn for eligibility for services? Do physicians have the training to identify LD children and prescribe treatment which is primarily educational in nature?

Obviously, the case may be overstated and the term "psychologist" or "optometrist" could as easily be substituted for physician, although it would probably be easier to justify the role of the school psychologist as gatekeeper of LD programs than the physician. But why not the <u>educator</u>? The point is, educators are the recipients of children who are often diagnosed and labeled by professionals outside education who have little or no information or training in education. The educators'

task, after diagnosis, has become one of "fixing" the child, with little or no support from outside sources.

Professionals outside education often naively assume that remedial treatment logically follows the stated diagnosis. Since education is not as scientifically precise as medicine, maybe the same premises do not hold. I contend that only one educational prescription for exceptional children exists. That prescription is an individualized, carefully engineered program. Regardless of the nature of the handicapping condition, whether the child is EMR, ED, LD or SM, the educational prescription will still be the same, i.e., individualized instruction. Therefore, to waste time defining and diagnosing may be foolish professional behavior.

On one point, most professionals would agree. There exist many children who have serious difficulty succeeding in school. Educators, as well as other professionals, can all agree "who" these children are. They cannot, however, agree "why" they are having difficulty or "what" they should be called. They can, in most instances, agree on "how" they can best be served in the classroom if they are not first excluded by some definitional contingency.

So it seems that attempts to define learning disabilities should be discontinued and efforts should be made to define services instead. Evelyn Deno first proposed what has been labeled the "cascade effect" of service delivery. It seems that this system is the only system yet developed that maximizes flexibility of programming, minimizes labeling, and completely avoids definitional arguments. Since few, if any clear differences exist in educational services for the different types of

exceptionalities, children can be identified for services by a multi-disciplinary team through a case conferencing procedure. This emphasizes the extent of service required to remediate or diminish the condition. The entire diagnostic procedure then becomes one of dealing with the "how" program for the child, rather than a game "what" to call him.

Reference

Coleman, J.C. Abnormal psychology and modern life, fourth edition. Glenview, Illinois: Scott, Foresman, 1972.

LET'S GET SOME QUESTIONS ANSWERED

James A. Poteet

To evaluate the effectiveness of instruction, Mager (1968) suggested the teacher must be able to answer three questions: (1) Where am I going? (2) How shall I get there? and (3) How will I know I've arrived? Those of us concerned with the learning disabilities section of Rule S-1 might do well to address ourselves to these concerns. If Indiana is to proceed with direction and purpose toward a scientifically-based, professionally-planned program for LD pupils, we must have these and other questions answered. When people ask questions, they tend to expose their ignorance and/or biases. "I'll show you mine if you show me yours." My concerns today will be with the diagnostic aspects of the LD sections.

Where Are We Going?

The Case Conference Committee has been delegated the responsibility of determining appropriate programming for LD children. The decision-making process to establish appropriate placement requires certain information. Those information needs must be specified so the diagnostician[1] can spend his time wisely obtaining data that will be used for decision-making. The report from the diagnostician containing this necessary and sufficient information is "where we are going?"

How Shall We Get There?

This overriding question must first be answered: Is a learning disabled child, by definition, neurologically impaired? Let us assume for the moment that the answer is "yes." If so, then the sequence of dianostic activities is clear: First, the referred child, already screened as a possible candidate for an LD program, has his first contact for diagnostic purposes with a

qualified physician to determine if a neurological impairment exists. If it does, the physician's written report must contain the following: (1) the general health status of the child; (2) physiological functioning and integrity of the child's peripherial senses, especially visual, hearing, and motor[2] (if additional input is required from another physician, this information must be included in the written report before it is finalized and forwarded to the Director of Special Education); (3) a statement that a vision, hearing, or motor handicap does or does not exist; and (4) the basis of the diagnosis of the neurological impairment and of the other handicaps, if they exist.

Second, with the above written report stating that the referred child is neurologically impaired, the next diagnostic activity must be conducted by the school psychologist[3] to determine if the child is learning impaired (disabled). Diagnostic activities are guided by the definition under which the school psychologist must work. At present, the Rule S-1 definition must be operationally defined almost word-by-word if an accurate diagnosis of LD is desired even though instrumentation (Hart and Hux, 1970) and guidelines for individual pupil study (Handbook, 1973) are available. Defining LD might be akin to the problem faced in defining "hyperactivity." Keough (1971) remarks "Hyperactivity is like pornography: hard to define, but you know it when you see it." They would not know it even if we saw it. Senf (1973) explains the developments leading to our present confusion over diagnosis. Procedures are discussed by Bateman and Schiefelbusch (1969).

Diagnosticians today differ in their orientation to the diagnostic process. One group searches for deficient within-child processes (such as "sound blending," or "auditory perception") thought to be etiologically related to LD. The process theorists are either language-oriented (Myklebust, Wepman, Kirk, etc.) or perceptual-motor oriented (Frostig, Kephart, Barsch, etc.)

A second group searches for specific skill deficiencies through task analysis. They look at the products of learning. This group is usually represented by those favoring a behavioral point of view.

Academic gains based on prescriptive activities resulting from within-child process diagnosis have been seriously questioned (Hammill, Goodman, & Wiederholt, 1974; Jones & MacMillan, 1974; Mann, 1971; Rosenberg, 1970) concerning the validity of its conceptual constructs. The within-child process approach is similar to the medical approach to the diagnosis of minimal brain dysfunction. Black (1973) notes that "positive neurological findings should not be a criterion for placement of children in remedial programs . . . (it) seems to be irrelevant in terms of the academic functioning of LD children, and would serve to eliminate remedial considerations of large numbers of children who would benefit from help" (p.47). Others (Chalfant & Scheffelin, 1969; Poteet, 1975) see process diagnosis as a subordinate level of diagnostic importance.

The characteristics traditionally attributed to LD children do not apply today (Bryan, 1974) and overlap with other classifications (Farrald & Schamber, 1970). Kirk's (1975) description of LD children served by Child Demonstration Centers indicates a general underachievement and a wide range of intelligence with no evidence of specific learning disability.

The instruments used to assess the within-child process have reliability and validity coefficients so low that they cannot legitimately be used to make meaningful decisions (Hammill, 1971; Ysseldyke, 1973). Their use with culturally different students is also questionable (Barnes, 1969; Sabatino, Kelley, & Hayden, 1973). The use of these tests is based on correlational studies that seldom show significant and never causal or etiological

relationships with the handicap. The discrepancy analysis approach between potential and achievement also has measurement pitfalls. The work of Asbury (1974), Farquhar and Payne (1964), and Salvia and Clark (1973) offer guidelines for proper interpretations.

The diagnostic approach needs to be based on direct observations of specified behaviors (Gardner, 1973; Lovitt, 1967). An emphasis on the use of informal assessment can be directly related to the education of the LD child (Hammill and Bartel, 1971, 1975; Smith, 1969; Stephens, 1970). Considering the questionable value of process diagnosis and the proven usefulness of task analysis, a change in philosophical approach to diagnosis and in the sequence of activities related to the diagnosis of learning disablities would be more educationally relevant (Quay, 1974, p. 169). Answers to questions aimed toward operationalizing terms in Rule S-1, therefore, become even more important.

The following approach involving different levels of diagnostic activity might allow for the existing variance in time, money, materials, facilities, amd personnel among the school districts in Indiana.

Level I rules out mental retardation, emotional disturbance, and environmental disadvantages. If any of these characteristics can be documented, the diagnosis for LD terminates.

Level II emphasizes diagnosis of appropriate task levels in academic skills. Informal assessment is used when necessary. If no "disorder" is found, diagnosis for LD terminates. Trial teaching of skill deficiencies should begin if deficiencies are identified. If there is no sign of improvement within a reasonable period of time, consultation activities should include observation of the interaction between the teacher and the student and peers, reinforcement contingencies in use, the difficulty level of the instructional materials, etc., before moving to the next level.

Level III considers a diagnosis of severe specific deficits in certain processes. Findings would relate to the method of instruction used in teaching the deficiencies at Level II. The focus here is on diagnosis of processing style or modality preference as seen with visual/auditory/haptic input-output success at appropriate developmental task levels.

A student would only be classified as LD after this level had been reached. The report from the school psychologist would: (1) note that the referred child is not mentally handicapped, emotionally disturbed, or handicapped because of environmental disadvantages (If additional input is needed from other professionals, such as a social worker, this information must be included in the final written report); (2) specify unlearned and learned academic skills and note where the appropriate task level for instruction should lie in a hierarchial relationship to the overall scope and sequence organization within each major content area; and (3) explain the processing type preferred for learning. This explanation should be related to the deficiencies found and guide instructional methodology.

How Do We Know We've Arrived?

We have "arrived" when the referred child begins to succeed in learning because of decisions made by the Case Conference Committee using the input from our diagnostic activities.

If an LD child, by definition, does not have to be diagnosed as neurologically impaired, the above sequence would still seem logical. The medical evaluation might simply eliminate the neurological component.

What We Must Do?

The highest priority of activities resulting from this conference must be to create several task forces, supported and financed primarily by the

Department of Public Instruction. These task forces must have the authority and responsibility to obtain factual data on which to answer questions necessary to operationalize scientifically-based programs for LD children. Cooperation among existing data-gathering committees, interested groups, and LD projects is necessary.

The Coordinating Committee for the Study of Learning Disabilities would be composed of the Governor of Indiana, the Superintendent of Public Instruction, the Director of Pupil Personnel Services, and the Director of Special Education. The responsibility of this top level committee would be (1) coordination of the task forces so input from each is integrated and correlated in a sensible and operational manner, and (2) dissemination of the final rules and regulations (guidelines) generated from the input of the task forces.

Characteristics of the task forces. (1) Each established Task Force must be composed of experts in the topic of concern. Members need not be limited to the state of Indiana. (2) The viewpoint, first and foremost, must be directed toward the education of LD children in Indiana. (3) Data from each Task Force must be operational. (4) Reports must be easily understood and easily disseminated. (5) Reports must be based on reliable, valid, scientific, and professional data. (6) Each task force must be given the finances and authority to obtain the data it needs. (7) A hierarchial list of information needs should be established and procedures implemented until all data are gathered. (8) A final report deadline should be determined and a time line of activities established to achieve the deadline goals. (9) Each Task Force must be aware that information needs and, consequently, the final report might be sectioned, as is the division of

Full-Time Special Classes found in Rule S-1.

The following Task Forces should be established to serve under the Coordinating Committee for the Study of Learning Disabilities:

(1) Definition. Terms must be operationally defined and a theoretical base thoroughly explained.

(2) Identification and Diagnosis. Screening procedures, possibly state-wide adopted, and re-evaluation tactics should be specified. Diagnostic approaches should be differentiated for each professional field as necessary (educational, psychological, medical). Specific tests, cutoff points, criteria formulae, degree of severity, etc., must be known by each and every diagnostician that has a responsibility for decision making. The responsibility for determining eligibility of a child for an LD program must be reviewed and the decision must rest with the educator.

(3) Programming. Curriculum concerns and their implementation, the building of appropriate learning disability Curriculum Guides, and decision-making procedures of the Case Conference Committee would be the focus of this group.

(4) Professional Education. Retraining of school personnel and physicians, preservice education at the university level, and future concerns would all be geared toward developing skills at all levels in all professionals at some time influence the education of LD children.

(5) Dissemination. A source to keep the practitioner and all interested people currently informed. The information must deal with new rules and regulations, trends, programs, theories, tests, resource centers, materials, diagnostic approaches, prescriptive activities, funding sources, research, etc.

(6) Parents. Parents' concerns and how they can best be met and possibly redirected by professionals, other parents, interested groups (ACLD), etc., would be the focus of this group.

Clearly, the three original questions of this paper raise other questions of a more basic nature: Is a general practitioner or a family practice center physician competent to determine neurological impairment relative to educational needs? What degree of "severity" does the rule mean? Should the word "perceptual" be changed to "receptive" in its place in the definition? How "specific" must the deficits be? What "educational skills" should receive priority in diagnosis? Can a list of qualified physicians be made available to school corporations? When these and other such questions are answered, we can then proceed with purpose.

Footnotes

[1]The "diagnostician" is used here to include all professionals who perform diagnostic activities (i.e. physicians, psychologists, teachers, etc.).

[2]Rule S-1 states that learning problems due primarily to visual, hearing, or motor handicaps are excluded from the definition of learning disabilities. If the physician finds one of these handicaps, then the child cannot be classified as LD.

[3]The word "school psychologist" used throughout this paper includes the functions of the school psychometrist.

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COMMENTS ON RULE S-1 AS APPLIED TO LEARNING DISABILITIES

Samuel B. Schnitzer

Rule S-1 indicates acceptance by the State of Indiana of its responsibility for the education of all the children in the state. S-1 represents a significant and forward-looking step in the implementation of the principle of equality of educational opportunity for handicapped children. Not unexpectedly, however, there are certain difficulties with the S-1 Rule as it now applies to learning disabled children. I should like to comment on two of these problems. Perhaps I should point out that, while I was not actively involved in the Indiana Association during the period of development of Rule S-1, I am aware of some of the arguments and views that resulted in the Rule as now constituted. Nonetheless, the need for comment remains.

The Medical Model

Learning disability falls under Section II, Part F of Rule S-1 titled "Programs for the Neurologically Impaired/Learning Disabled." This heading suggests one area of potential difficulty: The definition of the problem and the evaluation procedures required are suffused with what might be called a medical model of the condition. But, certainly, not all learning disabled children show evidence of medical problems that could clearly be considered causes of their difficulties. Indeed, most of these children probably do not show such problems, including syndromes labeled "neurological." Although some writers believe "minimal brain dysfunction" underlies all learning disabilities, such a view says no more than "mind is a function primarily of brain," i.e., brain mechanisms can be presumed to underlie all "higher" forms of behavior. Learning disability is not a disease state.

The model is compounded by the S-1 requirement that diagnosis of learning disabilities be made by a physician. Many nonmedical professionals seem better trained to diagnose learning problems than many physicians, including those specialists designated in Rule S-1. In addition, in most cases of learning disabilities, medical techniques do not provide the primary means of remediation. This does not suggest medical examinations of children are not advisable, rather that the physician is not necessarily the most qualified individual for making a differential diagnosis. He may actually have little or no skills in this area of concern.

In truth, S-1 has caused little difficulty. Physicians in the designated specialities have shown themselves capable of recognizing their limitations and appear to be cooperating with knowledgeable nonmedical professional workers. In addition, because of the rule, some specialists are beginning to train themselves to recognize learning disabilities.

Reinbursement Limitation

The potential for difficulties, however, still exists. One problem is the limitation to reimbursement for services to the learning disabled. Under Rule S-1, reimbursement for enrollees in learning disability programs is limited to a maximum of 1% of the total enrollment of any school corporation. This is the only category of handicap covered by Rule S-1 subject to such limitation. The minimum estimate that I have heard lately is 10%, and many estimates far exceed this value. Obviously, a school corporation dependent on State aid for help in funding special programs for this significant portion of its student population is severely restricted in the number of students it can service. And, in practice, there are indications that even this 1% maximum is often not reached.

An increase in funds for special education, including special education for the learning disabled, has been included under the budget passed recently

by the General Assembly. Thus, the financial picture might be somewhat improved, but current information indicates funds will still fall far short of what is needed.

The 1% limitation, then, probably presents the greatest difficulty in Rule S-1 for those interested in the education of learning disabled children. I realize that removal of the limitation could involve significant increases in state expenditures when the general economy is in dire trouble. But it seems that equity of opportunity for this category of handicapped children demands such removal. A more farsighted view of economy, in a broader sense, suggests the value of providing maximal opportunity for education for these children, many of whom could make important contributions to our society both at the state and national levels.

On the other hand, restriction of such opportunity could eventually be more costly than any increase in reimbursements now. For example, it would appear that 75% or more juvenile delinquents show some sort of learning disability. Although causal relationship has yet to be definitely shown, when all the behaviors associated with learning disabilities are considered, such a relationship does not seem improbable. It may be that appropriate expenditures for special education could help alleviate the human and financial costs that may otherwise be expected as the child matures.

A PARENT'S POSITION PAPER ON RULE S-1

Robert C. Reed

> "Blest are your eyes because they see and blest are your ears because they hear. To you has been given a knowledge... but it has not been given to others. Listen as they will, they shall not understand, look intently as they will, they shall not see."

The prophet Isaiah was not speaking of learning disabled children, but the words are appropriate.

In the minds of many parents, the following words of the prophet also apply to educators, administrators or professionals unconcerned with or uninformed about the plight of the LD child:

> "Sluggish indeed is this people's heart. They have scarcely heard with their ears, they have firmly closed their eyes; otherwise they might see with their eyes, and hear with their ears, and understand with their hearts...and we should heal them."
>
> Matt. 13:1,23

For this reason, it is especially gratifying to us to be able to present a paper to so many concerned groups.

Most educators or administrative officials would say that the parents of LD children assume one of two positions relevant to their children's problem--complete indifference or extreme vocal frustration. For these and other reasons, rapport between educators and parents is extremely low, and implementation of even the most basic of the tenents of Rule S-1 must suffer accordingly.

Indifference, after all, may be the result of inadequate or, more likely, uninformed explanations of the child's problem by those responsible

for his diagnosis and remediation (doctors as well as educators). Most parents are unable to understand either the technical terminology or the psychological and emotional consequences of LD. Furthermore, unless the educator has had special training in this field or has an LD child of his own, he may not be qualified to <u>try</u> to explain.

It is much easier for parents to accept the more easily understood and oft heard explanation that their child will "grow out of it" or is "really not trying hard enough."

In defense of concerned teachers, it must be said that it will be hard many times to obtain the necessary cooperation of parents, even when they do understand. In today's permissive society, many homes are unable or unwilling to institute the necessary discipline and structure these children must have.

On the other hand, once parents do understand, it is hardly fair to criticize them for getting vocally upset when they feel that an uninformed or unconcerned school system is willing to condemn their child and scores of others to a lifetime of frustration, emotional problems, unrealized potential, and possible delinquency. The parents are literally fighting for thier child's mind.

When the situation has been further complicated by actual misinformation from teachers, school psychologists, or physicians, the frustration is compounded. Much valuable time is lost, for instance, when the child and his family are referred by an uninformed psychologist to a psychiatrist instead of an LD teacher. Much harm is done by those in authority who consider the child's emotional or behavioral problem to be primary and the learning disability to be secondary and an outgrowth of emotional disturbance.

Problems with Rule S-1

Parents are concerned that implementation of Rule S-1 may be difficult or inadequate for the following reasons:

1. The 1% limit on numbers of children who can be treated as learning disabled in any school system has been labeled by almost everyone as a ridiculous, contrived, and politically expedient figure. Its only defense has been by those few who say that, at least, the worst afflicted will be taken care of under this rule. Sober reflection shows this to be false. It is a sad fact that the severely learning disabled child must leave the state of Indiana to receive adequate help, except for a pitiful few that are taken care of by organizat ons outside our educational system.

Most school systems fortunate enough to have a functioning program for remediation admit they can handle only those children diagnosed very early as minimally learning disabled.

Admittedly, there are centers of higher education within the state where there are programs designed to screen, diagnose, and prescribe for all LD children. However, these are few in number and primarily research-oriented. The children are returned to a system which is unable to administer the remediation program and where there is no follow-up.

It would be extremely interesting to see the politicians and educators who support or tolerate the 1% figure assigned to pick from the numbers of LD children in a school the ones they would save for a normal existence and those they would consign to a lifetime of frustration.

2. Many parents feel that, while the educators knowledgeable in the LD field are sincere and dedicated people, many are living in ivory (or

should we say ivy) towers.

Attending workshops, forums and meetings, we hear the following terms:

Case conference committee
School psychologist
School health officer
Counselors
LD teacher or therapist
Pupil personnel team

Principles and procedures of diagnosis and remediation are discussed as though all the above are available to the teacher or parent. In fact, however, if a poll were taken of the 315 school systems in Indiana, we fear you would be hard put to find anywhere near a simple majority that had even heard of LD, much less had a functioning program involving any or all of the listed professionals. Every year, the Indiana ACLD receives thousands of cards and letters from cities large and small asking where they can obtain help for their children.

In short, we feel that the size of the problem is underestimated, and the amount of help available is overestimated.

3. Programs do exist on paper in many school systems, but there is no systematic inspection or ongoing accreditation of these programs by the state to assure that they are being implemented and results are being obtained. Criteria for inclusion in a remedial program vary from system to system, county to county. Therefore, many children are denied proper aid when transferred to a new school.

4. Parents feel that a large segment of the learning disabled population has been totally ignored by both the law and the educators.

These are the children who have been socially promoted to fourth grade or above before being diagnosed. Very few systems within our state have any

remedial program for the LD child who is over nine years old. It is true that remediation of the older LD child is more difficult, but it is far from impossible if someone cares.

Since by definition the LD child is of average or above average intelligence, it seems unnecessary to note that all of them are worth salvaging, not just the young.

5. Parents feel that many educators are jealous of their own kingdom and permit no trespassing.

It is said that when there are many solutions to a problem, there is no really good one. This is not necessarily so. There are several good remedial programs for LD children in the state. Some are run by educators and some by educators and parents. Most are sure their program is the only answer. They are quick to find fault with another program, even though they have never visited or investigated it.

Parents who have investigated several programs and seen much good in most of them are perplexed and saddened when those in authority take such a narrow view. LD is a multifaceted problem and can be approached in several ways. Surely we can all learn from those around us with a minimum of criticism when we think of the desperate needs of these children.

6. We need a champion.

When comments such as the following are heard from those in highly responsible positions within our state educational system, it is apparent that there is no concerted effort to further strengthen or implement Rule S-1 at all levels:

"I doubt the necessity of requiring an LD course in the undergraduate curriculum of our teachers. Most teachers recognize their problem children."

"It will take at least fifteen years before we can have elementary teachers trained in learning disabilities in the classroom."

"What would we do with all those children after a screening program found them?"

"Be satisfied with 1%--you're lucky to get that!"

The overall impression parents come away with is that many educators and legislators are ducking an issue they are afraid of. Meanwhile, many thousands of children have gone down the educational drainpipe.

"Sluggish indeed is this people's heart."

7. There is a general unwillingness of the part of most educators to involve parents in any way in the active remediation of LD children.

There are many thousands of concerned and dedicated parents who could be involved in many ways in relieving the financial load on the school and the instructional load on the teacher. Oral testing, taping of books, helping with screening programs, and one-to-one tutoring fall within the province of parents (a successful program in California involves thousands, according to the Wall Street Journal).

Suggestions for Improving Rule S-1

1. Institute a statewide screening program to enable educators to give the legislators some informed idea of how many children need help. Only then can legislators arrive at some intelligent means of determining who qualifies for help and what monies are needed.

Such screening programs are already functioning in a few school systems within the state and elsewhere. Critics will say that there are imperfections within these programs and they would be right, but if we wait for the perfect program, we will never have any.

Most such programs have been proven to be practicable. Those who oppose the idea lay themselves open to charges that failure to support or initiate such legislative action is the result of an attempt to solve a problem by ignoring it.

Certainly, after these children are found, it is the duty of those administrators within the Special Education Department of our state to find some way to help them. Why else are they there?

2. Authorize the State Department of Education to require all school systems to report on the existance of a functioning program for LD children, and require follow-up reports.

Certain professional personnel, such as counselors, school psychologists and LD teachers, should be required, and these personnel should form the nucleus of a remediation team. The numbers and types of such personnel should, by law, be determined according to the size and location of each system.

Care should be taken to assure that members of a team are qualified by more than name only: A counselor should not be a part-time college special education major; a psychologist or psychometrist should have special training in recognizing learning disabilities. Many times, this is not true.

3. Considering that the learning disabled child constitutes the main challenge to the elementary teacher, is his/her main discipline problem, takes up more of his/her time than other students, and is the main disruptive force in his/her daily teaching programs, it seems unbelievable that many teachers who have received a B.S. in education have never even heard of the LD child.

It is true that the elementary teacher learns to "recognize problem students." The question is what the teacher does with him or her. The child is referred to the principal for discipline, to his/her parents for censure, and to the psychiatrist for therapy.

Surely, it is not too much to ask, for both the teacher's and the child's welfare, that a class on the recognition and remediation of learning disabilities be included in the undergraduate curriculum of the elementary teacher. Only then may teachers recognize the problem and refer LD children to the proper professional for remediation.

4. Lack of communication between trained professionals in the learning disabilities field and the parents of the LD child is obvious.

Many parents know "something is wrong with my child" but lose precious years in finding help.

It is obvious that the Special Education Division of the State Department of Education should do much more in the dissemination of information about the LD child to both the educator and the parent.

<u>The main reason for failure to remediate the LD child is not lack of desire on the part of the educator or parent but actual ignorance of the very existence of the LD child!</u>

In Summary

1. Parents are appreciative of the efforts of the numerous groups who are attempting to alleviate the problems of the LD child, but they feel more empathy between groups is needed.

2. Parents feel educators and legislators can only succeed in solving the problem when they succeed in defining and recognizing the entire scope of the problem.

3. Parents ask for and deserve a total commitment to the solution of this most pressing problem by those in high positions in our State Deaprtment of Education.

4. Parents want and deserve to be more involved in the remediation of these children.

5. Parents ask that educators be required to educate themselves in the recognition and remediation of their LD students.

Finally, please remember--"To you has been given a knowledge. . . but it has not been given to others." With the educators' expertise, the parents' dedication, and the child's perserverance, please God, we will give it to all.

S-1 REGULATIONS AND THE PEDIATRIC NEUROLOGIST

Arthur L. Drew

The early draft of the S-1 Regulations called for a pediatric neurologist to "certify" each learning disabled or minimal cerebral dysfunction child. Since there are only three board certified child neurologists in the state of Indiana, this requirement was fortunately dropped.

As a discipline, Pediatric Neurology has very little to offer in the practical educational management of the retarded, brain damaged, or learning disabled child. The issues are clearly educational, not medical or paramedical. The development of innovative and flexible teaching strategies is clearly the direct responsibility of education. The direct involvement of physician, whatever his persuasion,(occupational therapist, physical therapist, and others not in the main stream of education)has not been and will not be productive.

In a less negative vein, the pediatric neurologist has a professional interest in higher integrative functions of the central nervous system. This is an abstract scientific interest, unlikely at this point to be very helpful in the teaching process.

In unusual and complex individual children,the pediatric neurologist can be helpful in some differential diagnostic situations. An example might be the diagnosis of myotonia in a child labeled learning disabled because of an inability to produce acceptable written work in the time allotted by the teacher. Another example is unrecognized and untreated "petit mal" epilepsy or, in fact, gaining better control of any seizure disorder. These situations are few and far between and but a minor part of the problem of special education.

The pediatric neurologist (or pediatrician) can monitor those few children in whom a trial on drug therapy is justifiably considered.

There is a regrettable tendency to think of the EEG as an indispensible part of the evaluation of these children. The neurologist can advise, interpret and often save the parents the expense of an unnecessary procedure.

Finally, there are situations in which the rapidly declining prestige and authority of the pediatric neurology specialist (or other physician) may be brought to bear where either the school system or parents are unable to agree on proper placement of the child.

PEDIATRICIANS ROLE IN IMPLEMENTING S-1

Ladislas D. Wojcik

As a practicing pediatrician, I spend about 10% of my time seeing children with school problems. There are some in whom there is no identifiable medical problem - functionally or anatomically. But this can only be determined by thorough examination of each child.

There are some conditions one can identify; neuro-sensorial and muscular diseases are looked for but at an early age may not be diagnosed. Later, they will show up as developmental defects, but the diagnosis has been of little help to the educator. Sometimes the maturational pace, which varies from one child to another, may be an explanation for some school problems; these developmental abnormalities need no therapy. Even when there is something definite it usually follows that people with the same medical diagnosis differ widely in their ability to learn.

The only sensible approach to the evaluation of the handicap of a particular child is through teamwork. The physician, the psychologist, the educator and the social worker all must communicate and work together to come up with a reasonably accurate answer. The pediatrician must function as a co-equal member of this team. The physician can help in follow-up only if the school will communicate freely on medical aspects of care.

In some situations the pediatrician can best function as a general consultant to the school. Certainly the pediatric viewpoint will help solve some of the problems in school. Some aspects of the school situation might increase learning disabilities, e.g., dietary considerations as

related to hypoglycemia, drug use, unrealistic control on activity of children. Here the pediatrician can educate the school authorities as to the needs of these particular children.

In these situations the pediatrician can best function as a child-advocate. There should be an emphasis on learning ability NOT disability; an emphasis on the child's potential, i.e., the right of the child to an education that will allow him to fulfill his potential.

There should be only limited segregation of handicapped from "normals" - when it is to his benefit this child should be "mainstreaming."

Education of a child should be geared to his instructional age rather than I.Q. or chronological age.

The handicapped child needs stress on learning skills, self care, family life, and/or job goals.

In the final analysis the schools have the responsibility of diagnosis of learning ability or disability and provide proper programs for the child - however, pediatricians should be alert to inadequacies, undue stress, etc., as reflected in the child physically or emotionally.

There is a need for prevention of learning problems by early evaluation through the team approach and by early remedial programs. The optimum age for this approach is three years.

There is also a need for better identification of the learning problem. There needs to be a standardization of the medical exams. Routine school readiness tests also need to be standardized not only which test but by whom it is administered. There is a need to motivate parents so there can be intervention in infancy and proper regulation of day care. Lastly, there is a need to learn more about environmental effects on learning, about diet and hypoglycemia, about lead poisoning, and about exercise and how each of these singly and together effect the learning process of an individual child.

LEARNING DISABILITIES

Jack Fadely
Glenna DeBrota

Much has been learned in educational program, in medical clinics, and in endless other settings during the past ten years about how children learn, how they do not learn, and how too often our educational methodology falls far short of the needs of children in school. And while the concepts attending the notion of learning disabilities have failed to produce significant gains in solving our problems with children so called, our frustration can be turned to a new joy if we don't forget to see what has been learned. We have not learned so much about learning disabilities as we have about the very issues of how children learn and how we teach. The last ten years has seen neurologists and pediatricians talking to teachers, and parents joining the ranks of concerned individuals in the process of education. All of that, to be sure, has produced many highly frustrating interactions and defensive debates, and little more is known today about minimal brain damage then was known before. But if we turn away from the dogmatic position of attempting to rally about the learning disability flag and look at the mountain of new information available about learning climate and educational processes, the children will benefit. Those who linger about proclaiming the need for more learning disabilities programs or those of the opposite camp who wait in the shadows to scream "it is all nonsense", have little to offer. Each of these groups represent extreme views with probable vested interests which do not include providing increasingly effective educational programs.

There are children who have specific learning disabilities which should be more appropriately defined as children with specific neurological dysfunction. These children do not present a problem for specialists in the medical field, for the problems manifest themselves in obvious and incapacitating visual, motor, language, and intellectual disorders. While even in these cases the major intervention must be educational, often medication, diet control, family therapy, and other medical procedures can be of great assistance. In such cases, close communication and cooperation is needed between medical specialists and educators.

These children often need the availability of a full or part-time special classroom with teachers trained in many highly sophisticated educational interventions. This group of children also represent, unfortunately, an extremely small portion of any school population. In our experience with over 600 students referred for learning disabilities diagnosis during the last three to four years, less than one in ten could truly be called children with neurological difficulties. For those children who did manifest severe neurological difficulties, medical specialities easily agreed. Of this group of children, many also displayed a variety of additional emotional, social, and intellectual problems. But most of the children who were referred could not clearly be described as a child primarily with some sort of neurological disorder. Most of the children referred were more or less normal children with a variety of family, social, learning, and developmental difficulties which neither the school nor the family were successfully able to manage. Thus, most of the children we see are children who display developmental and learning problems primarily resulting from poor instruction and

and family management. The label of learning disabilities primarily served the function of removing the responsibility for the child's behavior from the parent and the teacher. While we have refused to provide the label for either the teacher or parent, we have found that specific information about developmental needs and good sound educational and family management approaches usually provide an effective basis for beginning to resolve the difficulties. We are not always successful, but the teacher and the parents usually can accept imperfection if our efforts can be cooperative toward eventual success. Taking the approach of learning disabilities more often then not confuses the issues and raises false hopes and eventual hostility by all concerned. This suggests that our problem lies not so much in the notion of learning disabilities but in the continual development of more effective ways to understand developmental needs of children as related to effective and flexible curriculum approaches in school. The issues are not the creation of a learning disabilities definition but rather an intense study of child development and school climate. That problem lies within the very heart of educational methodology and philosophy and not in special education. It is in this area that we have focused most of our attention in working with children and in training teachers.

For these reasons, we are not too interested in developing further a general increase in learning disabilities effort in public school programs. Rather, we would like to see a very limiting definition for children with severe neurological difficulties with associated special programs and an increased emphasis on curriculum development and teacher training within the regular curriculum in elementary and secondary schools.

The following criteria provide for us not a final or inflexible definition of children with severe dysfunction, but a list of basic factors which we use in an adaptive manner with each case. This list eliminates the majority of referrals from the realm of so-called learning disabilities and places them in the second classification of normal children with developmental or social problems who should be assisted within the regular classroom.

1. A full scale (Verbal/performance) IQ of no less than 90 points on the WISC-R, WIPPSI, or WAIS intelligence tests.

2. A language/age deficit of no less than three years as determined by psychometric tests, AND/OR
A developmental motor age score of no less than three years deficit in gross motor, fine motor, visual-motor, or perceptual motor areas.

3. Evidence of specific neurological dysfunction or deficit as determined by cooperative diagnosis by psychological, medical, and educational data.

4. Distractability and attention problems, hyperkinesis, disinhibitatory difficulties, and cognitive disorganization which cannot be accounted for due to emotional, sociological, nutritional/metobolic, or environmental causes.

5. A family/school history supportive of the foregoing data.

6. Evidence of positive prognostic signs for integrative development in specific learning areas, general adjustment potential, motivational structure, or other factors which indicate probable growth through short term intervention in special education.

Children who qualify for the foregoing criteria would be placed in intensified educational programming within the regular school environment with the goal of mainstreaming at the earliest possible time. Children who display more severe problems would be placed in segregated facilities for long term educational and medical intervention. Children who do not meet the criteria would remain the responsibility of the regular school curriculum.

It is obvious that, in order to complete the foregoing evaluation, several specialists must be included, such as the school psychologist, a medical staff member often in more than one special field, the parents, the teachers, and even nursing personnel. But, in our experience, when dealing with actual cases of neurological difficulties, some sort of team analysis and interaction is required. Without such team effort, endless numbers of children are labeled with a test score, a hunch, or actual incompetency not too short of criminal neglect. And at an early point in diagnosis, some individual professional must accept the responsibility for integrating the information for the parent and following through with intervention assistance. This point is perhaps one of ultimate importance since the alternative is often endless referral of the parent to another specialist, another blind alley, and eventual loss of important days and months. We suggest that this responsibility must be primarily with the school. And if that responsibility is truely met, then education will find much less pleasure in calling a child learning disabled, dyslexic, hyperactive, or designating him as having a perceptual motor disorder. For in most cases our problem rests not in the child so much as in our own competency as educators. Shall we begin again at the beginning?

In conclusion, may we add one important bit of information which, to our knowledge, has not been researched at all. This information could, if adequately pondered, lay to rest much of the interest in learning disabilities in education. Throughout the last five years in teacher education at the graduate level, we have given informal tests to over 500 elementary and secondary teachers in such areas as language abilities, motor-perceptual abilities, and cognitive function. Our conclusions from this very important research is that, in the normal population

of teachers, between 30% and 40% display significant learning disabilities that would preclude the probability that they might successfully finish school. The meaning of all this cannot escape us.

RULE S-1 & THE LEARNING DISABILITES TEACHER

Beckie Kichler

After "living" with the State Law concerning Special Education, (Rule S-1), I, as a learning disabilities teacher, see certain advantages and disadvantages to the bill. These are presented here. In addition, proposals for implementation and/or change of Rule S-1 are included.

Advantages of Rule S-1 include: (1) The procedure for special education placement is organized and systematic; (2) parental consent is necessary for each step in the placement of a child in a special education class; and (3) special education teachers are held more accountable for what they do in the classroom with the children.

Disadvantages of the bill include: (1) Psychometrists feel hesitant about recommending LD placement since THEIR opinions are given so much weight in placement; (2) parents do not understand a neurological approach and the therapist is little help in relating such information. Further, the components of a neurological examination are decided by the physician. Although the AMA has certain guidelines, these are not necessarily followed. Then, too, parents are often unable to pay for the neurological examination. Teacher are--by law-- prohibited from recommending a doctor for the parent's convenience. Many parents, thus, go to a general practitioner because they know no specialists. Because all this information is confusing, parents often feel that the process is too complicated to complete. If information were carefully and specifically presented more parents would follow through with this step.

(3) When the law is interpreted in the strict sense, it is difficult to place a student in the LD program. Neurological impairment is often

hard to spot in one test, and many students are refused placement due to the fact the test scores were normal. And soft signs are not sufficient for LD placement according to the law.

(4) Psychological test results are often insufficient for teachers. If, for example, the psychometrist gives the WISC, Bender-Gestalt, and the ITPA, the teacher does not have information that she/he needs to help the student in the classroom. She/he may know a student has difficulty in auditory closure, but what can be done? Many teachers do not know what that means and they do not have time to make individual worksheets for all their difficult students.

Other Point: (a) The testing does not necessarily measure the student's performance in class. It tests specifically what the student can do on a particular day on a particular test. (b) Teachers are concerned with specific problems in their particular subject area. They need concrete facts concerning student needs. Standardized tests do not always provide such facts. It is dangerous to put full faith in test results when studying reliability and validity scores of tests.

(5) Although medical information is a necessary part of the LD placement, it is of little or no help to the therapist. If I have a student who has suffered apparent brain damage, my educational program is not based totally on that information. Certainly the information gleened through a neurological examination is necessary for the placement. But the teacher does not and should not use that information in dealing with the educational concerns of a student.

Proposals

(1) Parents should have the right to demand service from the LD therapist.

A form should be prepared for parents to sign taking full responsibility for the placement.

(2) LD screening should be mandatory for all 1st graders entering a public school. This screening would be used solely as valuable information for the teachers and parent. In this way, many students would not go through several years of failure before help became available.

(3) Soft neurological signs should be made sufficient for placement in a Learning Disabilities program.

(4) Forms concerning the neurological examination should be available from the State Department for the principal to distribute.

(5) A full-time consultant should be allowed, by law, to help classroom teachers with students who do not make the eligibility requirements for LD placement.

(6) The State Department should set regulations as to the content of a neurological examination.

(7) Better psychological testing should be devised so that information gleened from the testing will be valuable to the teacher.

(8) More psychometrists are needed in the public schools to meet the demands of all testing requests.

(9) The school physician should be allowed to give a neurological examination at school by request of the parents. Forms should be available for this.

(10) The State Department should revise the Rule S-1 so that only one interpretation can be taken from the script. Today, rules and regulations are written in such terms that school corporations interpret the bill differently. The rules and regulations are ambiguous and conflicting.

INDIANA STATE TEACHERS ASSOCIATION

Rule S-1 Task Force

The Indiana State Teachers Association Rule S-1 Task Force was established as the result of a motion made at the fall, 1974, Indiana State Teachers Association Representative Assembly:

> I move that the ISTA Board of Directors appoint a task force composed primarily of teachers of special education who are operating under the provisions of Rule S-1 of the General Commission of the Indiana Department of Public Instruction, that this task force be charged with reviewing Rule S-1 as it affects the welfare of children, education, teachers, and the community and that the task force report its preliminary findings to the Board of Directors by January 1, 1975.
>
> Submitted by: Darvin Stilwell, NEA-Warrick County
> Seconded by: John Ransford, NEA-Mount Vernon
>
> Date: 10-19-74

The intent of the motion, as determined at the first meeting, was to review Rule S-1 as it affects special education programs in Indiana and propose changes identified by teachers and other professionals working in this field.

Since the group was formed in November, 1974, it has met five times to formulate plans for action. The ISTA Board of Directors voted to make the work of the Rule S-1 Task Force a part of the Indiana participation in the National Education Association's Project Educational Neglect. Project Educational Neglect was a special project of NEA President James Harris designed to bring together interested educators from across the country to focus on problems of educational neglect. One of the areas discussed was

neglect in education of the handicapped. Task Force members attended the four-day project conference in Washington, D. C., February 15 through 18. Out of this conference came an action plan and a tentative timetable for completing the directives of the original motion.

As part of the information gathering process, the Task Force distributed questionnaires and held a series of 11 regional hearings during the last week of April and the first two weeks of May. These two activities were carried out to gain input from special education teachers and other interested professionals to identify problem areas in Rule S-1 and to propose changes for improvement.

To carry out the remainder of the action plan, the Task Force plans to:

1. Hold a retreat to develop an ISTA position paper which will be submitted to the Board of Directors for approval.
2. Meet with representatives of other interested professional, governmental and service organizations to solicit their support and to submit proposed changes to the General Commission on Education and the Governor.

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*THE ROLE OF VISION IN LEARNING DISORDERS

Merrill J. Allen

Introduction

Certain fundamental visual characteristics are found in virtually all children who have difficulty learning to read.

There are several terms applied to learning disordered children which imply a degree of hopelessness for the child as well as confusion and frustration for parents and educators. Vision is obviously involved in learning. Nevertheless, educators' understanding of the role of vision in learning to read is largely derived from the conflicting statements found in textbooks designed for reading teachers.

The specific defects most often related to reading difficulties are hyperopia (far sightedness); lateral imbalances (one eye tends to turn in or out), especially if the child is also hyperopic; fusion problems; and poor duction ability (ability of the eyes to converge and diverge) which is closely related to fusion.

Nevertheless, many believe vision difficulties are not related to reading. This belief has lead to a multidisciplinary concept both in testing and treatment. The success of multidisciplinary handling of these cases is disappointing: The child is treated by a committee, valuable time spent in testing, often resulting in little specific therapy. We seem caught in a useless web of testing and referral for more testing.

Conclusions

Visual information processing depends on the child's ability to control the position of his eyes singly and together. Severe abnormality of this ability is observed in more than 90% of learning disabled children. Several

factors can cause poor oculo-motor function. Yet, animal studies and evidence of the incidence of high refractive errors in some newborns suggests that most learning disability probably begins during the first six months of life. This is due to a deprivation of quality visual stimulation.

Optometric clinical experience indicates that proper treatment can develop pursuit, saccadic, and focus control. Spectacles are often needed as part of the therapy and to care for refractive anomalies and binocular imbalances which also can interfere with information processing.

The visually treated child will be in a condition of visual readiness to learn to read. Without proper attention to the visual system in every learning disordered child, other procedures and techniques will most likely achieve results significantly below the child's potential and at a relatively high cost in time and effort.

*This paper is a summary of Dr. Allen's original text. The full paper is available on request.

THE OPHTHALMOLOGIST'S ROLE IN THE DIAGNOSIS AND TREATMENT OF LEARNING DISABILITIES

Eugene M. Helveston
Forrest D. Ellis

The ophthalmologist's role in the field of learning disabilities is as follows:

(1) He must evaluate any patient with a suspected eye disorder and treat any ocular abnormalities according to established ophthalmological principles.

(2) He must consult neurologists, psychologists, psychiatrists, pediatricians, social workers, and educators in the diagnosis and treatment of specific cases with a question of eye involvement.

(3) He must counsel parents, teachers, and other interested or involved parties so that unnecessary, ineffective, or inappropriate treatment does not obscure the correct diasnosis or delay the proper treatment.

(4) No scientific evidence supports the view that the eye alone has a role in the development or treatment of learning disabilities. Visual acuity, refractive errors, fixation behavior, ductions and versions, the 4Δ prism test, fusion amplitudes, stereoacuity, near point of accommodation, near point of convergence, color vision, strabismus, laterality, eye control, eye dominance and latent strabismus have been evaluated in children with learning disorders at Indiana University and other institutions. These have been found to have no relationship to the presence or absence of learning disability. Visual perception, which is related to maturity, may be enhanced by early training, though no evidence exists that this ultimately improves learning ability. Individual maturation is both variable and simultaneously influenced by so many factors that assessment of a specific treatment is difficult or impossible in scientific terms.

Certain treatment methods have been popularized by persons with varying motivations. These methods include the prescription of glasses for the sole purpose of treating a learning disorder, ocular pursuit movements, eye tracking, manipulating eye dominance changing laterality, and others.

Apparent success, usually related by testimonial, is sometimes achieved. We must be careful, however, that the credit for success is properly assigned. Objective interpretations of treatment results have suggested that the shift of attention to a child's problem area, relaxation of school and parental demands, and increased motivation on the part of the child may be more important than the treatment method.

The diagnosis of learning disabilities by examination of the eyes alone and treatment directed solely at the eye is naive and simplistic. Such diagnosis is deplored by ophthalmologists.

Diagnosis and proper classification of certain cases may be difficult and certainly requires cooperation among educators and various medical and allied specialties. The wide range of organic, psychological, and social factors that contribute to the learning disabled child's problems must be identified. Treatment methods must be directed to the proper target and results must be scrutinized scientifically. The role of the eye must be de-emphasized. We believe that enthusiastic, innovative, educational methods, scientifically derived and properly directed, will be the most effective approach to the management of learning disabilities.

CONSIDERATIONS FOR IMPLEMENTATION OF RULE S-1

Don A. Miller

Rule S-1 provides a set of guidelines by which local school corporations can fulfill their statutory responsibility for the education of all children residing in the State of Indiana.

This document represents a considerable amount of thought and hard work for the implementation of I. C. 20-10-26; I. C. 20-1-6; and I. C. 20-1-7. A maximum of contribution has been gathered from the various areas of public concern.

The present structure of Rule S-1, however, provides minimal assurance that educational programs proffered to meet special needs of handicapped children does the job and will continue to do so in the most relevant and timely manner. A most critical issue of these regulations should be the installation and maintenance of procedures whereby empirical determination could be made to ascertain (1) that all children seeking public school education have been so admitted and (2) that each program offers the most appropriate educational service from which the child can receive optimum benefit.

The preceding points to a glaring deficiency of Rule S-1. S-1 should require and/or make provision for a continuous evaluation system. This system would make apparent to the school corporation, local and state government, parents, and others that the program is or is not offering educational services to meet the special needs of each child, and that the services are or are not being provided with a high degree of efficiency and relevancy.

This evaluation would be a definite prerequisite to the annual case review of each student as outlined in Section II, sub-sections A through I,

paragraph 3. The evaluation system should allow for input from related concerns and independent unrelated evaluators, as well as for self-evaluation.

"To be fully effective, educational programming for students who may benefit from special education requires a team effort involving parents, teachers, school administrators, and specialists." (Rule S-1, Section II, third paragraph.) If this is to become a workable concept and a sincere statement,then an evaluation system using the above persons must be incorporated.

THE ROLE OF THE SCHOOL COUNSELOR IN RELATION TO LEARNING DISABILITIES AND RULE S-1

Sparkle Crowe

The school counselor has a significant role in the area of learning disabilities. The counselor's typical functions focus on the prevention or remediation of obstacles to a student's learning and personal development. He also helps to promote those conditions which best facilitate optimum learning and development. The counselor accomplishes this for the learning disabled student by utilizing specific skills. These skills include performing needs assessment, individual and group counseling, teacher consultation, career guidance, behavior management, placement, and other skills relevant in helping the learning disabled student.

The counselor can contribute by helping to identify the personal, social, or educational needs of students with learning disabilities discovered during preliminary screening or during later school years. Upon discovery of the learning disability and the student's concomitant needs, the counselor can initiate counseling sessions to discuss the student's concerns, provide encouragement and support, and help promote the student's self-esteem. Through individual or group counseling, students can also learn how to cope constructively with their learning disability. During the student's later school years, the counselor can assist by helping the student make informed career decisions. His knowledge of occupational training, placement, and financial aid can be invaluable assistance to students with a learning disability.

The counselor can provide assistance to teachers who have students with learning disabilities. He can help teachers enhance their communication and social interaction skills and increase their sensitivity to the special needs of the learning disabled. He can suggest ways of promoting self-esteem, suggest behavior management approaches for task achievement, and provide information for curriculum adjustments to meet student needs. The counselor can assist additional "significant others" by helping parents, peers, and others in the student's life to understand the learning disability, and thereby facilitate the student's learning and personal development. Finally, the counselor can be a viable member of the case conference team, contributing his unique skills in an integrated effort to help students identified as learning disabled.

THE ROLE OF THE PUPIL PERSONNEL TEAM IN RELATION TO LEARNING DISABILITIES AND RULE S-1

Sparkle Crowe

The pupil personnel team is typically composed of school psychologists, guidance counselors, social workers, and health specialists. All are concerned with preventing or removing obstacles from a student's learning and providing skills to maximize his development. However, to be fully effective, particularly when helping students with learning disabilities, pupil personnel specialists must work together as a team. The teamwork principle utilizes the full range of competencies possessed by the team's members. Pupil personnel teamwork has specific application to preliminary screening, needs assessment, case conferencing, evaluation, and in-service training.

Preliminary screening for learning disabilities is most effective when all components of the pupil personnel team participate. When the speech therapist, nurse, counselor, psychologist, etc., systematically screen new school entries, they are able to identify students with learning handicaps. From screening and further student needs assessment results, programs and learning experiences can be appropriately tailored for the student's benefit.

The case conference provides a vehicle for the pupil personnel team to give each student thorough attention. Successful teamwork, through the case conference, depends on mutual trust and frequent communication involving parents, teachers, administrators, and the pupil personnel specialists. The team provides an important function in recommending proper educational placement, and follow-up. It also plays an important role in the actual

program designed or recommended to meet the learning disabled student's needs. Through the team's participation, observation, and recommendations, the student can be better assured of receiving the best learning experience available.

In addition, the pupil personnel team provides both an important educational function by consulting parents, teachers, and others affecting the learning and development of these students and in-service training for these groups. Thus, the range of influence of the team concept is much greater in helping the learning disabled student than any one component working in isolation.

For the American Speech and Hearing Association's position on learning disabilities contact:

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GROUP I: DEFINITION

PROBLEM: To broaden or to narrow the definition of Neurologically Impaired/Learning Disabilities as presented in Rule S-1.

RECOMMENDATIONS:

A. Keep the 1% figure in Rule S-1.

Rationale: Until more data has been collected as to the actual incidence of severe learning disabled children in the schools, it is recommended that this figure of 1% be kept unchanged in the rule. Discussion generated in the group indicated the 1% was probably an accurate figure of severe incidence in the State. Discussion participants were widely dispersed throughout the State and from a wide variety of disciplines. Further, it was felt that this figure would allow only the severely disabled child to get the necessary learning assistance, and would leave to the regular classroom those children whose problems were mild to moderate, but that it did not exclude special consultative help to regular classroom teachers.

B. No introduction of IQ limits.

Rationale: By specifying general integrity limits in the present rule, it is felt that "average" IQ is already contained in the definition.

C. A definition clarification is necessary.

Rationale: An operational form of definition is needed so that teachers in training, parents, and regular classroom teachers may better understand the definition of a learning disabled child. This clarificaiton should be one of inclusion rather than exclusion, and

should remain sufficiently broad to include all types of learning disabilities of a severe nature. This clarification follows:

STATEMENTS FOR DEFINITION CLARIFICATION:

1. The Learning Disabled student is significantly below expectation in basic educational development.
2. The Learning Disabled student exhibits a clear pattern of intra-individual differences in either process or product terms.
3. The Learning Disabled student exhibits general integrity in his/her ability to learn.
4. The Learning Disabled student can be expected to progress through the use of either remedial and/or compensatory techniques of teaching.
5. The Learning Disabled student has had a documented diagnostic-teaching process applied in the regular school classroom program over a significant period of time. This process may involve specialists such as speech therapists, learning disabilities consultants, psychologists, reading specialists, or others. Designation of the child as Learning Disabled should be made only after this process has indicated characteristics indicated in statements 1-4 of the clarified definition and should be supported by data which indicates that the regular classroom program is insufficient in meeting the individual needs of the child.

GROUP II: ELIGIBILITY

PROBLEM: To identify children who could benefit from services designed for the learning disabled.

RECOMMENDATIONS:

Eligibility should be recommended by a variety of people all of whom should be trained to some degree to recognize signs of learning disabilities.

1) Parents should be educated to recognize some signs of possible disabilities in their own children.
2) There should be mass screening of all school children during first two years of school, preferably before first grade. Teachers and principals are in need of education to recognize signs in the children.
3) Standardized testing should follow. Psychometrists should be educated in learning disabilities in order to do a more effective evaluation.
4) The physician should be the last to diagnose. More education of diagnosis of l.d. is needed for physicians.

Eligibility should be determined and recommendations and prescriptions made by pupil personnel services acting as a team in the case conference. Elementary counselors with training should be included on all pupil personnel services teams.

The 1% of school population allowed by the state for learning disabilities is merely the limit of what the state will give reimbursement for. This does not mean this is the limit of l.d. children possible.

GROUP III: DATA GATHERING

PROBLEM: Lack of specificity of an evaluation procedure and content.

RECOMMENDATIONS:

Pre-conference--could be on building level:

1. Referral Form (teacher)
2. Parents' Form or Checklist
3. Physical Form or Checklist

Areas of Evaluation:

1. Psychological
    a. Intellectual
    b. Emotional
2. Educational
    a. Achievement
    b. Emotional
3. Perceptual
4. Speech and Language
5. Visual
6. Auditory
7. Social
    a. Emotional
    b. Family
    c. Adaptive (outside of classroom)
8. Specialized medical evaluation

Rationale: Current regulations and/or practice do not mandate actual procedures for data gathering or the nature of the required evaluations.

Each of the areas, in and of itself is important when you consider the breath and complexity of the theoretical construct of learning disability. To overlook any area would be to prevent dealing with the etiology and may negate the evaluation and prevent effective remediation.

GROUP IV: PLACEMENT AND DUE PROCESS

PROBLEM 1: The first issue was that of the role of the physician. It was generally agreed that the physician had a role in evaluating children with learning problems to eliminate or rule out physiological causes such as malnutrition or or metabolic dysfunction.

RECOMMENDATION:

Entry into the medical services system should be through the "primary" physician which in most cases would be the family doctor. The primary physician could perform a general evaluation and make a referral if necessary to a specialist for more thorough examination in specific areas. The above might be a procedure to be followed across all handicapping categories.

PROBLEM 2: While Rule S-1 does specify that eligibility for an NI/LD placement be established on the basis of a report by a physician, it does not say what information this report should include, e.g. does an abnormal EEG finding constitute support for an NI/LD placement.

RECOMMENDATION:

The placement and programming recommendations should come from the Case Conference Committee and therefore is the appropriate group to "interpret" the educational implications of the physician's report.

PROBLEM 3: While Rule S-1 spells out various due process procedures such as the appeals procedure, parental understanding and awareness need to be ensured.

RECOMMENDATION:

Since the case conference can be reviewed as a quasi-legal proceeding, parents should be able to bring along an advocate or representative, e.g. lawyer, neighbor, ACLD representative, professor, etc. This might help parents in understanding and securing their rights. Other mechanisms which might facilitate the above would be a check-off list for parents to ensure that all due process' concerns were addressed during the case conference and an audio tape of the proceedings in case questions arise as to what due process issues were or were not addressed.

PROBLEM 4: The specific points within the hearing procedure appeared adequate.

RECOMMENDATION:

It was felt that the procedure by which hearing officers were selected and trained should be specified.

PROBLEM 5: A concern was raised regarding the most appropriate placement for a given child. If the most appropriate placement does not currently exist within the school system what options are available to the parents and the case conference committee? How can we avoid having the committee look only at presently available placements in recommending the most appropriate placement?

GROUP V: PROGRAMMING

PROBLEM 1: Many regular classroom teachers feel unable to cope with the learning disabled child who is mainstreamed into the regular classroom setting.

RECOMMENDATIONS:

University training programs for regular elementary and secondary education majors should include required courses geared toward the mainstreaming of learning disabled children into the regular classroom. Course content should cover individualized instruction techniques, knowledge and use of appropriate materials and equipment, instructional methodologies for the learning disabled child, and methods of fostering an attitude of positive acceptance toward learning disabled children.

PROBLEM 2: Rule S-1 does not require that information from the case conference committee include prescriptive activities and an educational program.

RECOMMENDATION:

Prescriptive programs should be detailed prior to placement decisions.

RATIONALE:

Appropriate placement can only be determined after considering specified educational activities.

GROUP VI: EVALUATION

PROBLEM:

1. Validity of case review as only an annual review.
2. Evaluation of child, program, placement, or all three.
3. What are the criteria for evaluation?
4. Staffings vs. annual case conference meetings.
5. Parental involvement in evaluation (recourse for school)
6. Neurologists and other medical personnel participation at annual case review.
7. Financial reimbursement for teacher time spent in review and evaluation.

RECOMMENDATIONS & RATIONALE:

1. Suggest need for ongoing evaluation, not just a yearly conference. Need for using systematic ongling evaluation to determine efficacy and validity of program. What falls under the jurisdiction of case review in terms of changing program? What kinds of changes can teacher initiate without calling meeting? Need for criteria for evaluation, i.e., rating scales, observation systems, checklists, etc.
2. Suggest an annual case review; individually evaluate child, program, and placement separately as different issues.
3. Criteria for evaluation needs to be specified at initial case conference. Evaluation should be as objective as possible based on rating scales, observation systems, checklists, etc.
4. Staffings become part of ongoing evaluation and frequency of these meetings be child based.

5. Parents should be involved in case review continuously and throughout the year. Close liaison between parents and teachers. Evaluate pupil progress jointly and continuously. School personnel must inform parents as to all alternative placements and their rights through due process proceedings. Encourage active parental involvement. School should serve as team advocates for child in review. Parents should not be required to make decisions immediately. Do parents legally have total veto power at case reviews and case conferences as well at initial case conference?
6. Financial considerations for money for inservice training, etc., so that evaluation is not just a final step in the procedure but so that it can become an integral realistic part of what is actually happening to the child. Also need money available for release time for teachers and other personnel to carry out evaluation activities and to participate in case review process. Money for additional supportive personnel (aides, etc. to supplement evaluation activities).

EPILOGUE

Indiana's current legislation mandating services for children designated learning disabled reinforces the ambiguity that exists in the field. In the authors' opinion, our rules and regulations reflect a professional failure to define and make explicit the behavioral characteristics of the learning disabled child. As a result, Rule S-1 includes no complete operational definition expressed in terms that could be useful for making relevant educational decisions.

Indiana's Rule S-1 has placed emphasis on defining special children rather than special needs before providing services to exceptional children. Unfortunately, programming based upon labels or categories is often worthless for attaining educational objectives. More importantly, issues involved in determining the most effective means for delivering services to children or the most appropriate strategies for individualizing education are not necessarily addressed by placing a child within a "category"--no matter how precise its definition seems to be.

These considerations suggest that those professional and lay persons writing legislation designed to facilitate the education of children with learning problems should be concerned with the operational requirements of meeting specific educational needs rather than matching children to definitions. Legislation dealing with the special needs of children should not focus on identifying discrete categories of children as a prerequisite for providing services. Instead, it should concentrate on establishing mechanisms for determining individual educational plans based upon information derived from behavioral manifestations of learning problems and situationally specific variables.

Legislation should provide alternative plans for meeting the special needs of exceptional children. Programming--not placement--should be stressed. Each child's educational needs should be considered, and services should be based upon specific intervention strategies designed to meet his/her individual needs. This approach should ultimately prove more beneficial to the learning disabled child than the "sort", "classify", and "place" procedures typically outlined in state legislation.

Specifically, the authors recommend the following changes in Rule S-1 and guidelines implementing this rule:

1. Definitions should be expressed in terms acceptable to all professional disciplines. Any definition adopted should possess clarity and utility for all professionals involved.

2. Guidelines should describe services and/or delivery systems based upon special needs rather than provide a label for a child.

3. Initial evaluations should be made through an interdisciplinary approach for all children with special needs.

4. The case conference approach can best assure involvement of all disciplines, protect the rights of the LD child, afford parents due process, and provide best possible learning processes for the child. The case conference approach needs to be strengthened. Options for programming need to be carefully delineated.

5. Alternative programs must be made available to meet the need of students whose potential can best be achieved by various processes of education.

6. The statutory advisory council should represent each of the disciplines involved, e.g., education, medicine, psychology, social work, with the assistance of a legally qualified consultant.

7. Rule S-1 should be reviewed by this body for specific changes considering the recommendations developed by this conference and expressed during these proceedings.

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